

Notice of Independent Review Decision

DATE OF REVIEW: 07/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 5xWk x 2Wks 80 hours 977990 Lumbar/Cervical

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the Chronic Pain Management Program 5xWk x 2Wks 80 hours 977990 Lumbar/Cervical is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 07/03/12
- Decision Letter from – 05/25/12, 06/21/12
- IRO Appeal from Dr. no date
- Referral from Dr. to Dr. – 06/14/12
- Letter from Dr. to Dr. – 04/18/12
- Appeal/ Reconsideration from Dr.– 06/06/12, 06/14/12
- Mental Health Evaluation by Dr – 05/17/12
- Chronic Pain Management Program Treatment Plan/Progress Report by Dr. – 05/17/12
- Functional Capacity Evaluation – 05/07/12
- Prescription History by Claim – 06/15/12
- Office visit notes by Dr. – 11/06/92 to 11/30/92
- Report of Medical Evaluation by Dr. – 05/31/95, 10/11/95
- Office visit notes by Dr. – 05/31/95 to 11/03/95
- Operative Report for Discogram by Dr. – 11/15/95, 06/26/98
- Operative Report for Cervical Surgery by Dr. – 03/29/96
- Report of MRI of the lumbar spine – 08/15/97, 02/07/12

- Operative Report for lumbar facet injections by Dr. – 10/02/97
- Operative Report form radio frequency thermocoagulation by Dr. 11/13/97
- Second opinion by Dr. – 07/10/98
- Second opinion by Dr. – 07/24/98
- Report of Nerve Conduction Study/Electromyography – 08/14/98
- Post-operative note by Dr. – 02/18/99
- X-ray report of the thoracic spine – 05/08/07
- Report of MRI of the cervical spine – 07/07/09, 02/07/12
- Physician notes from emergency department visit - 05/17/10
- Report of MRI of the thoracic spine – 07/07/10
- Notes for follow up visits to Clinic – 01/13/12 to 04/12/12
- Report of drug screening – 02/13/12
- History and Physical from 02/16/12 admission to Hospital – 02/16/12
- Preauthorization request from Accident & Injury Rehab – 05/22/12
- Mental Health Evaluation from Accident & Injury Rehab – 05/17/12
- Progress report for Chronic Pain Management Program – 05/17/12
- Patient Daily Notes from Accident & Injury Rehab – 05/07/12
- Letter from Dr. to Dr. – 06/14/12
- Re-print of ODG Treatment/Disability Duration Guidelines , Low Back Chapter – 06/19/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when she fell while cleaning a shower resulting in low back pain radiating into the left lower extremity. She also complained of neck pain which radiates to both shoulders and arms with tingling and numbness to the fingers of the right hand. Diagnostic testing included x-rays, MRI's, discography and FCE's. She has been treated with medication, chiropractic care/PT, epidural steroid injections, lumbar facet injections, radio-frequency thermocoagulation and cervical surgery. She was placed at MMI by a DDE on 10/11/95 with a 20% whole body impairment rating.

The patient had a repeat cervical and lumbar spine MRI on 02/07/12. A surgical consultation revealed that she was not a surgical candidate. A second surgical opinion confirmed that she was not a surgical candidate. A comprehensive FCE was performed on 05/07/12. A thorough mental health evaluation was performed on 05/17/12

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The records indicate the request for this interdisciplinary chronic pain management program was accompanied by treatment plan/progress report detailing treatment area/deficits with baseline data as well as short-term goals and long term goals. The ODG's indicate the outcome and the necessity of the program should be clearly identified with desirable outcomes including decreasing post treatment care including medication. Treatment is not suggestive for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and

objective gains. It should be documented that the patient has motivation to change and is willing to change her medication regime (including decreasing or actually weaning substances known for dependence).

The criteria requirements for use of the multidisciplinary pain program as set by the ODG for this patient have been met. The records indicate that there is evidence of unsuccessful methods of treatment. These methods have not resulted in significant clinical improvement. The records do include documentation of patient response via VAS scale. All diagnostic procedures necessary to rule out other treatable conditions have been completed prior to the treating doctor's consideration of this patient as a candidate for a chronic pain program. There is documentation that the patient has the motivation and will to change.

In conclusion, the patient has exhausted all other treatment options. The recommended chronic pain program will allow her the best opportunity to decrease fear avoidance, learn more effective pain control methods, set realistic goals for recovery, develop and execute a plan to change careers if necessary and help her learn to cope with her feelings of depression and anxiety so that she can again participate in previously pleasurable activities. The records indicate she expressed a strong interest in the services, indicating she would be compliant with the program requirements and treatment interventions. Therefore, it is determined that the Chronic Pain Management Program 5xWk x 2Wks 80 hours 977990 Lumbar/Cervical is medically indicated.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)